

**WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (CSED) WAIVER
REQUEST FOR SPECIALIZED THERAPY AND/OR ADAPTIVE EQUIPMENT
(To be completed by the Case Manager)**

Name of Person Who Receives Services		Date	
Medicaid Number		Type of Residence (✓)	<input type="checkbox"/> Natural Family
CM Agency			<input type="checkbox"/> Foster Care Family
CM Name			CM Signature
CM Phone #			

Specialized Therapy/Adaptive Equipment Requested for (✓):

Specialized Therapy (Must be prior authorized by MCO)

Type of Therapy Requested: _____

Adaptive Equipment (Must be prior authorized by MCO)

Type of Equipment or Service Requested:

Did the CM ensure request meets service description in the Policy Manual? *(Check credentials of the Specialized Therapist according to the policy manual. Is the Adaptive Equipment requested listed in the policy manual as acceptable)?*

Yes No

Brief description of Specialized Therapy/ Adaptive Equipment requested (Invoice including itemization of materials and services on contractor letterhead must be attached):

Total Amount Requested Specialized Therapy/Adaptive Equipment combined cannot exceed \$500.00 per service year \$

Vendor Information

Vendor Name:	
Vendor Address:	
Vendor Phone #:	
Vendor Qualifications:	

A copy of the following documentation must be sent to the MCO for processing and determination:

- PCSP recommendations detailing need for the ST and/or AE
- The invoice detailing costs and description of the ST and/or AE
- If approved, receipts for the ST and/or AE must accompany this form and be sent to the MCO.

Signature/Name of Person Who Receives Services		Date	
Representative Signature		Date	
Case Manager Signature		Date	